Reference Number:	738-01-DD
Title of Document:	Discharge Planning for Those Leaving ICFs/MR and Enrolling in the Mental Retardation/Related Disabilites (MR/RD) Waiver
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Applicability:	Community ICFs/MR, Regional Centers

PURPOSE:

To establish the expectations of the South Carolina Department of Disabilities and Special Needs (SCDDSN) regarding discharge planning for residents who will need services funded by the MR/RD Waiver upon leaving a Regional Center or Community ICF/MR.

POLICY:

SCDDSN is committed to supporting South Carolinians with disabilities through choice to receive needed services in the most integrated settings when it is appropriate and desired. To assure that needed services are available to newly discharged ICF/MR residents on the day of discharge and beyond, appropriate planning prior to discharge must occur.

ICF/MR residents who are preparing for discharge **must** receive Service Coordination Services (SCS). Services may be received for up to six (6) months prior to ICF/MR discharge. These services are intended to prepare the resident for discharge, thereby deterring the need for institutional (ICF/MR) care, by assessing needs, facilitating the delivery of services to meet those needs, and monitoring the success of those services. Service Coordination Services are paramount to successful discharge from an ICF/MR.

When ICF/MR discharge is likely (i.e., within 6 months), Qualified Mental Retardation Professionals (QMRPs) or designees must provide residents and their legal guardians information about SCS (Attachment 1) and the SCS providers available in the county in which they will live after discharge. Residents/legal guardians must choose which company or agency they want to provide services. The choice must be properly documented using the ***Acknowledgement of SC/EI Choice*** (Attachment 2). Once chosen, the resident/legal guardian or the resident's QMRP or designee must contact the SCS provider to request services. The caller must be prepared to provide basic demographic information, information about the anticipated setting in which the person will live, the approximate ICF/MR discharge date, and supports/services likely to be needed in the anticipated setting. If the chosen SCS provider is not willing to provide services, another provider must be chosen and the aforementioned process followed until a provider is found.

The chosen SCS provider will assign a Service Coordinator who will provide SCS to the ICF/MR resident. Services will be in accordance with SCDDSN Standards for Service Coordination and applicable SCDDSN policies and procedures. Services provided will be reported to SCDDSN using the "Invoice For Discharge Planning from ICF/MR and Enrolling in the MR Waiver Program" (Attachment 3). SCS providers can report activity as often as monthly for up to six (6) consecutive months prior to their discharge from the ICF/MR. For example, for someone discharged from an ICF/MR on June 15, an invoice may be submitted for reportable activities provided, prior to discharge, during June, May, April, March, February and January. Invoice forms must be sent to the Finance Department at SCDDSN.

ICF/MR services are funded by Medicaid. In South Carolina, the Mental Retardation / Related Disabilities (MR/RD) Waiver, operated by SCDDSN, allows services, similar to those provided in an ICF/MR, to be funded by Medicaid when provided outside of an ICF/MR. Therefore, this Waiver allows ICF/MR residents to move from the ICF/MR to another setting (e.g., a home of their own, a family member's home, Community Training Home, Supervised Living Program, Community Residential Care Facility) that is not an institution (e.g., Nursing Facility, Hospital, another ICF/MR) and receive Medicaid funding for services needed in that setting. For many ICF/MR residents, living outside of an institution would not be possible without MR/RD Waiver services. SCDDSN Medicaid Funded Service Options (Attachment 4) contains more information about the MR/RD Waiver.

In order to receive MR/RD Waiver services, one must be enrolled in the waiver. To be enrolled, one must:

- be eligible for Medicaid;
- be assessed to have needs that can be met through the provision of waiver services,
- be allocated a waiver slot,
- choose to receive services through the waiver, and
- meet ICF/MR Level of Care criteria.

For ICF/MR residents preparing for discharge, a ***Request for MR/RD Waiver Slot Allocation-MR/RD Form 30*** *(*Attachment 5) must be completed by the Service Coordinator within no less than one month prior to discharge from the ICF/MR and sent to the appropriate SCDDSN District Office. At the same time, the ***Community Residential Admission/Discharge Report*** (Attachment 6) will need to be completed and sent to the appropriate District Office Assistant Director (refer to 502-01-DD for more specifics regarding discharges/admissions).

When a slot is awarded and the ***Notice of Slot Allotment-MR/RD Form 5*** (Attachment 7) is received, the Service Coordinator must secure the Freedom of Choice and Acknowledgement of Rights and Responsibilities from the appropriate party.

For MR/RD Waiver enrollment, one must be evaluated against the ICF/MR Level of Care criteria prior to, but not more than one month before, enrollment in the waiver. Waiver enrollment cannot occur unless the person is determined to meet the criteria and the determination is made within the appropriate time period. Level of Care evaluations for those entering the waiver must be conducted by SCDDSN's Consumer Assessment Team (CAT). To determine if someone meets the criteria, CAT must receive appropriate information about the person (i.e., Level of Care Packet). The Level of Care Packet must be prepared by the Service Coordinator with assistance from the QMRP or designee and must include:

- A completed **Request for MR/RD Level of Care -MR/RD (Form 9)** (Attachment 8).

- A formal psychological evaluation(s) that includes cognitive and adaptive scores that support a diagnosis of mental retardation or a related disability or documentation that supports that the person has a related disability such as a report from SCDDSN Autism Division, or appropriate medical, genetic or adaptive assessments. If available, the person's SCDDSN Eligibility Letter should be included.

- A current plan including Behavior Support Plan, if applicable.

- Current information about the person's ability to complete personal care and daily living tasks, behavior/emotional functioning, and physical health status. For ICFs/MR, the Code of Federal Regulations at §483.440(b)(5)(i) - [*W203*] requires that a final summary of the person's developmental, behavioral, social, health and nutritional status be developed. The QMRP or designee should provide this final summary to the Service Coordinator for inclusion in the Level of Care Packet.

When the Level of Care evaluation is complete, the CAT will provide notification as appropriate.

Once the ICF/MR resident has been assessed to have needs that can be met through the provision of waiver services, has chosen to receive services through the waiver, has been allocated a waiver slot, and has been determined to meet ICF/MR Level of Care, he/she is ready for enrollment in the MR/RD Waiver. Actual enrollment, however, cannot occur until the person is discharged from the ICF/MR. In most situations, the MR/RD Waiver enrollment date will be the date the resident is officially discharged from the ICF/MR.

If during the enrollment process, the ICF/MR resident decides not to pursue MR/RD Waiver enrollment, the ***Statement of Individual Declining Waiver Services - MR/RD Form 20*** (Attachment 9) must be completed. When completed, the original should be maintained in the SCS record and a copy maintained in the ICF/MR record. A copy of Form 20 will also be sent to the District Waiver Coordinator. If the Form 20 is not sent to the District Waiver Coordinator, the enrollment process would continue.

For ICFs/MR, the Code of Federal Regulations at §483.440(b)(5)(ii) - [*W205*] requires that a post-discharge plan of care be provided that will assist the person to adjust to the new living environment to which they are moving. The MR/RD Waiver requires that *only* the services included in the plan of care be provided. If any waiver services are to be received immediately following discharge from the ICF/MR (e.g., residential habilitation), appropriate planning prior to discharge from the ICF/MR must occur.

The Service Coordinator, with input from the QMRP or ICF/MR Service Coordinator, will develop <u>one plan</u> that documents both the post-discharge plan that will assist the person to adjust to the new living environment and the MR/RD Waiver services to be furnished, the provider type and amount, frequency and duration of

service to be delivered and meets both IFC/MR and MR/RD Waiver requirements. This one plan must be in the format required by the MR/RD Waiver for use as the Plan of Care.

Once the plan is developed, service providers can be selected by the resident/legal guardian and authorized to provide services immediately following discharge / enrollment (i.e., effective date of authorization = the date of MR/RD Waiver enrollment).

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Attachment 1: Service Coordination Services
Attachment 2: Acknowledgement of SC/EI Choice
Attachment 3: Invoice For Discharge Planning from ICF/MR and Enrolling in the MR Waiver Program
Attachment 4: Medicaid Funded Service Options
Attachment 5: Request for MR/RD Waiver Slot Allocation (MR/RD Form 30 ICF/MR)
Attachment 6: Community Residential Admission/Discharge Report
Attachment 7: Notice of Slot Allotment-MR/RD (MR/RD Form 5)
Attachment 8: Request for MR/RD Level of Care (MR/RD Form 9)
Attachment 9: Declining Waiver Services Statement (MR/RD Form 20 ICF/MR)